(3)

No. 98-215

In The
Supreme Court of The United States
October Term 1997

ANDREA HELLER,
Petitioner,

v.

FORTIS BENEFITS INSURANCE COMPANY,
Respondent.

Petition For A Writ Of Certiorari
To The United States Court of Appeals
For The District of Columbia Circuit

REPLY TO BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

Whether the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1133 (1994), which provides that "every employee benefit plan shall-- (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim," permits an employee benefit plan to deny benefits with minimal notice and no appellate review of a participant's claim, as found acceptable by the Court of Appeals for the District of Columbia Circuit.

Whether a failure of an ERISA benefit plan to provide adequate notice of the bases for denial of an employee benefit claim and its failure to provide any appellate review of the decision to deny the participant's claim, as sanctioned by the Court of Appeals, encourages litigation and unnecessary resort to the federal courts relating to benefit plan decisions better left to an administrative process, as contemplated by 29 U.S.C. §1133?

Whether the Court of Appeals, contrary to rulings by other federal Courts of Appeals, was correct in approving restitution of benefits paid by an insurance company benefit

plan administrator to a participant admittedly disabled when neither the plan documents nor any correspondence from the insurance company to the participant indicated that restitution was permissible nor anticipated?

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STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the District of Columbia Circuit (Court of Appeals) was entered on May 1, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTORY PROVISION INVOLVED

Section 1133 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1133, states, in relevant part, that "every employee benefit plan shall-- (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in such a manner calculated to be understood by the participant, and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."

STATEMENT OF THE CASE

Despite Respondent Fortis' admitted failure to advise Petitioner Heller of her right to appeal in its denial letter and the letter's failure to conform to the requirements of the regulations, the circuit court closed its eyes and held in a result-oriented decision that the letter constituted "adequate notice" of the denial. It then concluded that by filing suit, Heller had waived any right to a meaningful review process, ignoring the reality that no such review process even existed, and that she was made well aware of this violation of the statute and regulations by Fortis, through counsel, giving her no other option but litigation. It ignored the actual response of the Fortis claims manager to Heller that no effort by the participant or her attorney would prompt it to reverse its position on appeal and the admitted fact that the appeal process essentially was non-existent. The best Fortis can now do to justify this prostitution of the law and applicable regulations is to claim that Heller is not really permanently disabled so the rules need not apply to her.

The circuit court also ignored Heller's status as a plan participant, equally entitled to protection of the statute. Furthermore, it incredibly confused the Fortis insurance company's assets with a pension plan's assets and somehow reasoned it was better to protect the insurance company than a plan participant never put on notice of an intent by the carrier to seek restitution. Most law students would know the distinction between a non-waiver letter and a notice of intent to seek restitution, but the lower court did not. Thus, the

circuit court found that the district court did not abuse its discretion in ordering the unemployed and disabled Heller to pay restitution for these payments to Fortis. Such result-oriented holding is unique in American law and remarkable in its viciousness to a health plan participant.

ARGUMENT

I. THE MEDICAL AND VOCATIONAL TESTIMONY DEMONSTRATE THAT THE ISSUES OF HELLER'S PERMANENT DISABILITY AND INABILITY TO WORK ARE, AT BEST, CONTESTED.

Under the guidelines established by Fortis, a termination of disability benefits requires sufficient medical documentation to support such determination. Contrary to Respondent's Brief in Opposition, Heller's permanent disability was an issue that was not at all settled, but rather much contested. The two Independent Medical Exams that showed that she was not a "qualified injured worker" and that she "was not totally disabled from gainful employment" were conducted by Dr. John Devor and Dr. Luis Levitt, physicians hired, respectively, by a worker's compensation insurance company or by Fortis itself. Furthermore, Dr. Levitt spent no more than 15 minutes on his examination of Heller or his review of her records. Under Fortis' own guidelines, such summary disposition of a claim for disability benefits is clearly inadequate to constitute sufficient grounds for termination.

In contrast, Dr. Raymond Drapkin, Heller's treating physician, determined on numerous occasions that her pain and injuries were irreversible and that she was totally disabled

under Fortis' definition. Both Dr. Drapkin and the occupational specialist hired by Fortis to evaluate Heller recommended part-time work at a sedentary job. Both the lower court and Fortis admitted that the opinions of a treating physician, who is naturally more familiar with the health history of a claimant, must be accorded greater weight than those of a single-examination physician. At best, the issue of her disability was very much disputed and never determined by a trial. Indeed, the District Court refused to accept an Affidavit from Dr. Drapkin regarding Heller's permanent disability, despite it providing clarification on this issue. As to the error of this approach, *see Luby v. Teamsters Health, Welfare and Trust Fund*, 944 F.2d 1176, 1184-85 (3d Cir. 1991); *Wolfe v. J.C. Penny Co.*, 710 F.2d 388, 394 (7th Cir. 1983).

In *Helms v. Monsanto*, 728, F.2d 1416, 1421 (11th Cir. 1984), the court held that "there is scarcely any kind of disability that prevents them from following some vocation or other, except in cases of complete mental incapacity . . . . The insured is not to be deemed 'able' merely because it is shown that he could perform some task." *See* Germany v. Operating Engineers Trust Fund, 789 F. Supp. 1165 (D.D.C. 1992). Despite evidence showing that Heller's her disabilities require her to spend a significant portion of each day resting in bed. Despite such evidence, Fortis continues to insist that Heller is able to work as an "inside salesperson." Part-time is not comparable to full-time work under the policy definition of disability, but the circuit court inexplicably ducked this issue, as well.

Fortis claims that Heller's ability to work is evidenced by her employment at her husband's law firm, even though there was no evidence, as the District Court had to admit. Larry VanDraska, an investigator hired by Fortis for the specific purpose of spying on Heller to determine her lifestyle, observed both Heller's home and her husband's law firm for five days and hired a police detective to paw through Heller's and the law firm's garbage without obtaining any proof of her employment. He also obtained a health insurance enrollment form that mentioned Heller but failed to notice that three weeks later, the mistake was corrected. At no time did he attempt to obtain payroll records of the law firm, Heller's social security employment record, or her tax returns or make a direct inquiry of Heller's employment to anyone at the law firm. Rather, he based his curious, illogical, and preordained determination of Heller's employment at the law firm on the answer, "she's not here," that he received when he called the firm and asked to speak to her. Such outlandish judgment on the part of Fortis evidenced not Heller's health or ability to work, but only Fortis' predisposition that it would deny her disability benefits no matter what the factual investigation showed. In *Masella v. Blue Cross & Blue Shield of Connecticut, Inc.*, 936 F.2d 98, 107 (2d Cir. 1991), the court held that ambiguities under ERISA must be construed against the carrier. The D.C. Circuit, oriented to other interests, follows a different course. However, given the evidence of Heller's total disability and her inability to work, the only proper conclusion is that Fortis' unexplained termination of her disability benefits was wildly erroneous.

II. FORTIS FAILED TO PROVIDE ADEQUATE NOTICE AND MEANINGFUL REVIEW AS REQUIRED BY 29 U.S.C. §1933 (1994).

As Fortis admits, ERISA requires that a plan provider terminating benefits give the beneficiary or claimant adequate notice and meaningful review in writing and within 60 days or in limited occasions justified by special circumstances, within 120 days. 29 C.F.R. §2560.503-1(h)(1)(i); 1(h)(3); *see Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 688 (7th Cir. 1992). In *Murphy v. Wal-Mart Associates' Group Health Plan*, 923 F. Supp. 700 (E.D. Tex. 1996), the court found that the letter denying benefits was acceptable under ERISA when it contained the reasons behind the decision, listed the phone number for obtaining assistance in filing an appeal, and referenced the page numbers in the employee handbook outlining the necessary steps for appeal. However, in *White v. Jacobs Engineering Group Long Term Disability Plan*, 896 F.2d 344 (9th Cir. 1989), the Ninth Circuit found that a notice of termination violated 29 U.S.C. §1133 where the plan provider gave only conclusory allegation of gainful employment, failed to substantiate its decision, and failed to adequately inform the beneficiary of the type of information that he needed to submit to appeal the decision. The Third Circuit held in *Epright v. Environmental Resources Management, Inc.*, 81 F.3d 335 (3d Cir. 1996), that a notice of termination was inadequate where the letter did not explain the procedure for requesting review of the decision. *See McLean Hospital Corp. v. Lasher*, 819 F. Supp. 110 (D. Mass. 1993). Furthermore, in *Wilczynski v. Lumberman's*

Mutual Casualty Co., 93 F.3d 397 (7th Cir. 1996), the Seventh Circuit concluded that a plan provider's stonewalling of a claimant's attempts to obtain a copy of the claim file in order to file an appeal constitutes a denial of meaningful access to full and fair review.

Fortis maintains that it provided adequate notice and appeal procedure in accordance with ERISA. However, Fortis clearly violated 29 C.F.R. §2560.503-1(h)(1)(i) by failing to advise Heller of any appeals process in its benefits termination letter. Once Fortis sent Heller this brief letter notifying her of its denial of her benefits, 60 and then 120 days passed with no notice of any appeals procedure. Moreover, the evidence at trial showed that the so-called appeals process employed by Fortis involved review by the same person who made the initial finding of termination, the insurance company claims manager. Fortis also avoids the cold fact that Fortis' representatives told Heller's attorney on at least one occasion, shortly before suit was filed, that there was no review procedure and that even if there were one, no information that he could submit would alter their initial determination. Contrary to claims that Heller failed to utilize the administrative remedies available to her but filed suit immediately upon its denial of her benefits, administrative remedies were well exhausted. Certainly, it would have been more expeditious to have appealed the termination through Fortis if such review process had existed in any form, but it did not. Given the outrageous practices of Fortis, there was never "substantial compliance" with the regulations. The circuit court closed its eyes again to this sham. The facts

demonstrate that review was not optional; Heller had to file suit because she had no alternative. Rather, the failure of Fortis to provide any meaningful appeal process gutted the supposed guarantees under ERISA. To deny review here is to approve such deception by plan providers and only brings shame on the system.

III. FORTIS WAS NOT ENTITLED TO RESTITUTION UNDER 29 U.S.C. §1933 (1994).

Despite the absence of clear authority that authorizes restitution under ERISA and the conflict in the circuits regarding the availability of this remedy under 29 U.S.C. §1933 (1994), the circuit court held that ERISA allows for such remedy to an insurance company on the present facts. Thus, it ordered Heller to reimburse Fortis for payments totaling $19,811.00 made from January 1991, the expiration of the first five-year period, to January of 1992, on the basis that these benefits were paid to Heller without any admission of liability. However, Fortis' Plan does not provide for restitution, and Fortis never mentioned to Heller any possibility that it would seek restitution for payments later deemed mistaken. When Fortis informed Heller that its continuance of disability benefits was not an admission of liability, it did not suggest that those benefits were conditional on a confirmation of her eligibility. Surely, most courts understand the distinction between a reservation of rights letter and a notice of intent to seek restitution. Given that existing ERISA case law either prohibits or, at best, does not clearly provide for this remedy and that Fortis failed to mention this remedy until Heller filed her suit, Fortis had no

entitlement to the restitution of disability benefits it paid to Heller. To approve the circuit court's contrary holding is to provide insurance companies in the field of health program administration a draconian club not heretofore available to them. And they hardly need such a weapon, given the inequality of bargaining strength between them and a disabled claimant.

In its Brief in Opposition, Fortis cites cases that do not bear on this issue. Despite its heavy reliance on *Blue Cross and Blue Shield of Alabama v. Weitz*, 913 F.2d 1544 (11th Cir. 1990), that case related to a plan that sought relief from third parties. Fortis also cites *Luby v. Teamsters Health, Welfare and Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991), where the court considered death benefits inadvertently paid to a non-beneficiary by union trust funds to which union members contributed dues. Unlike recipients in *Weitz*, Heller is a participant in an employee benefits plan, not a non-party beneficiary. Moreover, Fortis is a third-party insurer administering an employee benefits insurance policy on behalf of an employer for its employees, unlike the union in *Luby*. Again, *Luby* involved payments to a non-beneficiary from union-member contributions, not to a plan participant such as Heller from insurer fund to which she had been previously entitled. The reasoning of either case is inapplicable to the present facts.

In addition, Fortis fails to notice the distinction between pension funds and employee benefits plans when it cites *Crown Cork & Seal Co. v. Teamsters Pension Fund*, 549 F. Supp. 307 (E.D. Pa. 1982) and *Whitworth Brothers Storage*

Co. v. Central States, Southeast & Southwest Areas Pension Fund, 794, F.2d 221 (6th Cir. 1986). Fortis maintained an employee benefits plan, not a pension plan but Fortis fails to realize that the two types of programs are distinct in their contribution and payment structure. Unlike a pension plan, where the "pool" available to plan participants is limited by the contributions and deductions, Fortis' disability policy was simply an insurance policy with funds actuarily set aside. When Fortis made the payments for which it now claims Heller was ineligible, no other Plan participant was harmed by the deduction of this sum from the Plan. Likewise, if Fortis recoups those payments from Heller, no other Plan participant will benefit from the addition of this sum to the Plan. Only Fortis will increase its profit margin, at the expense of an unemployed, admittedly disabled, fifty-one-year-old woman. Consequently, the lack of legal authority allowing restitution to employee health benefit plans under ERISA, the Plan's silence on such entitlement, the hornbook rule of law that such insurance policies are always construed against their drafter, and Fortis' failure to ever notify Heller of its intent to seek restitution leads to the logical conclusion that restitution is not a remedy available to Fortis or any insurance carrier on these facts. *See Hill v. State Farm Mutual Insurance Co.*, 237 Va. 148, 375 S.E. 2d 727 (1989); *CUNA Mutual Insurance Society v. Norman*, 237 Va. 33, 375 S.E. 2d 724 (1989); *Virginia Farm Bureau v. Jerell*, 236 Va. 261, 373 S.E. 2d 913 (1988).

CONCLUSION

A recent appellate court stated in regard to judicial readings of ERISA:

> That a statute whose clear purpose was to benefit employees has become widely used as a shield to protect employers from any deceptive and wrongful acts that they have committed against their employees is an irony that we find unacceptable as a governing principle of law. *Layland v. Plymouth & Brockton St. R.R. Co.*, 44 Mass. App. 427 (1988).

If the words insurance company are substituted for employer, the above language fits this case perfectly. If fair play means anything in the ERISA context, this Court should grant the requested writ.

Respectfully submitted,

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